Washington State Health Care Authority

Alternative Benefit Plan Strawman

The Patient Protection and Affordable Care Act (ACA) defines a new, mandatory eligibility group of non-pregnant adults, between ages 19 and 65, with modified adjusted gross income up to 138 percent[1] of the federal poverty level. This group must receive benchmark or benchmark-equivalent coverage described under section 1937 of the Social Security Act, and modified by the ACA to include all essential health benefits. This is known as the Alternative Benefit Plan (ABP).

GOALS:

Washington State Medicaid's ABP is being designed in the context of overarching goals and principles for the Medicaid expansion.

- Capitalize on opportunities to streamline administrative processes
- Leverage new federal financing opportunities to ensure the Medicaid expansion is sustainable
- One common benefit for Medicaid adults to achieve administrative simplicity and equity for consumers across income categories
- Maximize use of technology to create a consistent consumer-friendly health care coverage application, enrollment, and renewal experience
- Maximize continuity of coverage and care as individuals move between subsidized (insurance affordability program) coverage options and Medicare
- Reform the Washington way --- comply with, or seek waiver from, specific ACA requirements related to coverage and eligibility, as needs are identified
- Emphasize use of evidence-based care and demonstrated best practices (including utilization review) to ensure benefits covered balance ACA requirements and prudent limitation on state fiscal exposure
- Leverage analysis and design criteria on which Washington State's Health Benefit Exchange Benchmark plan was based[i]
- Recognize the opportunity for refinements in the future, while ensuring the feasibility of implementing the preliminary ABP design on January 1, 2014[2].

[1] The ACA sets Medicaid income eligibility at 133 percent of the FPL but with a 5 percent across the board disregard, that effectively becomes138 percent of the FPL.

[2] States are not required to update Alternative Benefit Plans that have been determined to include essential health benefits as of January 1, 2014, until December 31, 2015. States will adhere to future guidance for updating benefits beyond that date, as described by the Secretary.

ASSUMPTIONS FOR MODELING WASHINGTON'S ABP OPTIONS:

After interagency discussions, discussions with CMS staff, guidance provided by CMS in the January 22, 2013[3] proposed regulations for essential health benefits in ABPs, State Medicaid Director letter of January 16, 2013, concerning the application of mental health parity and addiction equity, some questions still remain toward completing Washington's ABP design.

What follows is a summary of elements that must be included in the ABP and assumptions to expedite actuarial modeling that will inform the fiscal elements of Washington's ABP design and the broader discussion of a common benefit for all Medicaid adults.

- Analysis of scope of benefits to be included in the ABP begins with the current Medicaid Standard adult benefits package included In the State Plan. This is being compared against a list of Essential Health Benefit (EHB) reference plans defined in federal rule (e.g., FEHBP, largest HMO, state employees, and largest small group product.) Regence Innova is the small group plan that was selected as the state's benchmark reference plan for the Exchange.
- The existing Medicaid Standard benefit plan includes all 10 EHB categories. Identification of meaningful differences that must be applied to ABP coverage will focus on benefits only, not specific provider types which are addressed through network development and provider contracting for delivery of service.
  - ***Habilitation services must be offered***. CMS has invited comment on whether the definition of habilitation services being used for the qualified health plans should apply to Medicaid or whether states should be allowed to define habilitative services separately for Medicaid. For purposes of preliminary analysis, the strawman benefit design will assume parity between the existing Medicaid rehabilitative benefits (speech, occupational and physical therapy) and a new habilitative benefit, which is similar to the approach taken by the Office of Insurance Commissioner. This would include the application of existing visit limits for adult enrollees. Further analysis is being performed to determine the extent to which currently provided services meet the definition of habilitation, which will impact future fiscal models.
- ***Newly eligible adults who meet the definition of "medically frail" are exempt from mandatory enrollment in ABP coverage*** although they could choose ABP coverage. An additional eligibility review (e.g., current CSO incapacity standard) would be required to measure "medical frailty" for the purpose of bypassing mandatory ABP coverage if it differs from Medicaid Standard. This added complexity and cost is a key reason that the strawman design focuses on a common adult benefit for new and currently eligible enrollees, built on the foundation of the existing standard benefit.
- ***Preventive Services will need enhancement to meet ACA requirements***. The proposed federal rule makes it clear that the Medicaid ABP will be required to cover the same preventive services outlined in the ACA. This includes: "A" or "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright

[3] http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf

Futures program/project; and additional preventive services for women recommended by Institute of Medicine (IOM). For the most part, the existing Medicaid benefit covers the full spectrum of required preventive services, with the exception of Screening, Brief Intervention, and Referral to Treatment (SBIRT).

- Alcohol/drug screening and brief intervention services are included in the State Plan (attachment 3.1-A, page 38.) Activation of SBIRT billing codes would be limited to trained emergency room and primary care providers who follow specific evidence-based guidelines.
- ACIP vaccines recommended by the ACIP (list released January 28, 2013 in Annals of Internal Medicine) are all covered except for the Shingles vaccine for adults age 60 or older.

- ***Regardless of the ABP design, the mental health benefit will require adjustment*** for all Medicaid managed care plans and newly eligible adults in fee-for-service, to meet the federal Mental Health Parity and Addiction Equity Act (MHPAEA).[4] The strawman assumes mental health parity across all Medicaid populations.
  - Under MHPAEA, benefit limitations and restrictions for mental health or substance abuse services must be no more restrictive than similar limitations applied to a medical or surgical benefit.
  - Clarity of policy and coordination of operations across Medicaid managed care, fee-for-service and Regional Support Networks will be necessary to administer this modified benefit.
- The management of substance abuse service delivery with priority for Medicaid enrollees and within Washington's expenditure authority does not appear to limit or delay access to necessary substance abuse services. Follow-up discussions are scheduled with CMS to confirm this interpretation of ***Washington's existing chemical dependency benefit***.
- ***If a decision is made to reinstate an adult dental benefit,*** associated costs for newly eligible adults would receive 100 percent federal match from 2014-2016, gradually declining to 90 percent federal match in 2020 and thereafter. The benefit for currently eligible adults would be matched with 50% federal funds.

STRAWMAN DESIGN FOR COMMON ADULT BENEFIT:

To meet the federal requirements for an Alternative Benefit Plan for newly eligible adults and to achieve a common benefit for all Medicaid adults, key design elements would include:

1. Start with the current Medicaid standard benefit
2. Addition of ACA-required preventive services
3. Addition of habilitative benefit in parity with the rehabilitative benefit
4. Adjustments to meet mental health parity.

[4] www.medicaid.gov/Federal-Policy-Guidance/.../SHO-13-001.pdf

TIMELINE OVERVIEW – Critical Steps:

STEP	DATE	Done
Request to CMS for guidance on ABP design	7/24/12	✓
Review ABP Options with stakeholders, Leg staff (pre CMS guidance)	12/11/12 – 12/12/12	✓
CMS guidance on ABP design	1/14/13	✓
Consultant assessment of CMS guidance (Manatt)	1/22/13	✓
Select Medicaid Standard as base benchmark plan	1/28/13	✓
OIC/HCA/ADSA workgroup comparison of Medicaid Standard/EHB reference options	1/28/13	✓
Preliminary differences identified /documented	1/31/13	✓
OIC/HCA/ADSA workgroup follow-up(s)	2/4/13 – 2/8/13	
Preliminary selection of options to be modeled	2/4/13	✓
Substance abuse payment brief (for CMS review)	2/6/13 (draft) 2/8/13 (final)	
Milliman modeling (using CFC caseload estimates)	2/6/13 – 2/22/13	
Assess impact on Tribal behavioral health delivery	2/6/13 – 2/13/13	
Follow-up with CMS to confirm assumptions on mental health/substance abuse	CMS revised schedule to 2/13/13	
Review preliminary results with Leg staff	Wk of 2/25/13	
Align fiscal modeling with Legislative budget timeline	**3/1/13**	
Legislative expenditure authority	Session end	
State Plan Amendment request	Spring 2013	
Implementation activities (contract amendments, consumer communications, system activities, programmatic policy & procedures, CMS approval etc.)	**10/1/13** **(MAGI eligibility determination Go-Live)**	